IN THE
UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 17-2530
Criminal

UNITED STATES OF AMERICA,

Appellee,

v.

JOHN EDWARD SCHOSTAG,

Appellant.

Appeal from the United States District Court
for the District of Minnesota

BRIEF OF APPELLANT

MANNY K. ATWAL
Assistant Federal Public Defender

ERIC RIENSCHE
Research and Writing Specialist
U.S. Courthouse, Suite 107
300 South Fourth Street
Minneapolis, MN 55415
(612) 664-5858
Counsel for Appellant

SUMMARY AND REQUEST FOR ORAL ARGUMENT

Appellant John Schostag is serving a term of federal supervised release. He suffers from a number of health problems, including addiction disorder as well as a vexing chronic pain condition due to severe physical damage.

While on supervised release, Mr. Schostag made good progress with addiction treatment, but was unable to solve the chronic pain problem. After trying numerous medicinal and non-medicinal therapies for months on end, he consulted a physician who recommended a regimen of state-permitted medical cannabis. All of his healthcare providers—his pain specialist, addiction specialist, and primary care physician—concurred with this course of treatment.

Having begun the therapy, Mr. Schostag's probation-office-administered drug test came back positive for marijuana. At a revocation hearing, he informed the district court of the above facts, after which the district court determined it had no choice but to impose a prohibition against the use of medical cannabis.

As this brief will show, the district court erred as a matter of law in failing to recognize that it had the option to order treatment so that healthcare professionals could determine whether medical cannabis was an appropriate therapy, or not. This appeal appears to raise an issue of first impression which is likely to recur, so 10 minutes for oral argument is requested.

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TABLE OF ABBREVIATIONS

Abbreviation	Description
App.	Appendix
DCD	District Court Docket Entry
Def. Ex.	Defense Exhibit
FRAP	Federal Rules of Appellate Procedure
RHT	Revocation Hearing Transcript (DCD 1342)
RHT2	Second Revocation Hearing Transcript (DCD 1372)
ST	Sentencing Transcript (DCD 1352)
USSG	United States Sentencing Guidelines
VR	Violation Report (DCD 1295)
VR2	Second Violation Report (DCD 1359)

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JURISDICTIONAL STATEMENT

Appellant John Schostag was charged by indictment filed in United States District Court for the District of Minnesota. (DCD 1). Crimes against the United States were alleged, (*id.*), thus implicating the district court's original jurisdiction, 18 U.S.C. § 3231. The Honorable Donovan W. Frank, Senior United States District Judge, presided at all proceedings relevant to this appeal, including original sentencing and supervised release hearings. (DCD 715, 739, 1317).

The district court entered its order modifying conditions of supervised release on June 23, 2017, (DCD 1316), and Mr. Schostag filed his notice of appeal on July 7, 2017, (DCD 1326), which was timely pursuant to FRAP 4(b). This Court has jurisdiction to decide the present appeal pursuant to 28 U.S.C. § 1291 and 18 U.S.C. § 3742(a).

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STATEMENT OF THE ISSUE

I.

When an individual on federal supervised release tests positive for medical cannabis, does a district court have the legal option to order out-of-court treatment rather than impose a penalty and/or modify conditions of supervised release?

United States v. Kaniss, 150 F.3d 967 (8th Cir. 1998)

United States v. Pierce, 132 F.3d 1207 (8th Cir. 1997)

18 U.S.C. § 3583

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STATEMENT OF THE CASE[1]

I. John Schostag

John Schostag has a drug problem. Or to state it with more nuance, his life has been plagued by problems—both legal and health-related. Most stemming directly from drug use. (*E.g.,* ST 5-8, 21-23).

He suffers from debilitating addiction disorder, for example. And along with that, co-occurring conditions including depression and anxiety. This state of affairs has led him to self-medicate all the more. The vicious cycle would continue on and on, reinforcing itself every time around. (ST 5-8, 21-23; App. A, B).

His cravings led him to compulsively ingest a number of substances—cocaine, oxycodone, and methamphetamine to name but a few. All highly addictive. All hazardous. (DCD 639 at 2-3; ST 5-7; RHT 6-7).

His life descended into utter chaos. His addictive drug-seeking introduced him to buyer side of narcotics commerce. And as all-too-often occurs, he eventually drifted to the seller side. In 2008, he was charged with conspiracy to distribute methamphetamine, unlawful possession of that same substance, and unlawful possession of a firearm. (DCD 1 at 2-4, 19-20).

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[1] Parenthetical citations are described in the TABLE OF ABBREVIATIONS, *supra.*

To the latter pair of charges, he pled guilty. (DCD 458, 485). At sentencing, he described his addiction disorder, along with his many other health challenges. (DCD 639 at 2-3; ST 5-7). The court readily accepted all of this, including his need for addiction treatment while in prison and beyond. (ST 14, 22-23, 27-29, 30-31).

The district court ultimately imposed a 120-month term of imprisonment. (DCD 739).[2] On top of that, a 5-year period of post-imprisonment supervised release. (DCD 739). As part of the latter, a number of conditions were announced, aimed at addressing his addiction and other health challenges, *e.g.,*

- "[T]he defendant shall refrain from excessive use of alcohol and shall not purchase, possess, use, distribute, or administer any controlled substance or any paraphernalia related to any controlled substances, except as prescribed by a physician."

- "The defendant shall participate in a program for substance abuse as approved by the probation officer. That program may include testing and inpatient or outpatient treatment, counseling, or a support group. Further, the defendant shall attend Alcoholics Anonymous/Narcotics Anonymous meetings and make a good faith effort to obtain and maintain a sponsor."

- "The defendant shall participate in a psychological/psychiatric counseling or treatment program, as approved by the probation officer."

- "The defendant shall take any prescribed medications as directed by his medical provider."

(DCD 739 at 3-4).

[2] The term of imprisonment was later reduced to 100 months because of the change in the applicable Federal Sentencing Guidelines. (DCD 1139).

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II. Supervised Release

By late 2015 Mr. Schostag had completed his prison term, and thus began the mandated period of supervised release. All the aforementioned conditions came into play at that time. (VR 1).

He started outpatient addiction treatment. But he soon experienced "struggles with sobriety," particularly methamphetamine usage. (VR 4). This is why he tested positive for that drug in late 2016, and again in early 2017. (VR 1). In the first instance, the district court imposed 14 hours of community service, and told him to keep up his efforts in this drug/alcohol treatment program. (DCD 1276). In the second, the probation office elected not to pursue sanctions, but rather continue with the treatment regimen. (VR 1). By March 2017, he had completed the addiction treatment program. But a great many challenges remained. (VR 4).

The trouble was, addiction wasn't his only health problem. Not by any means. He suffers from a chronic physical pain disorder—caused by toe amputations or some other damage to the feet. He has gone to specialists. He has tried numerous non-drug therapies. He has tried over-the-counter medications. He has been deemed medically ineligible for some medications (*e.g.,* prescription opioids), due to his addiction disorder. This has gone on for nearly two years—from the time of his release in 2015 to present. Nothing worked. Nothing could control the pain.

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The reality is this: individuals suffering from chronic pain while coping with substance use disorder are in a maddening dilemma. The medications most commonly employed to treat the pain are also highly addictive, such that treatment of one malady risks exacerbating the other. This is precisely the bind that Mr. Schostag found himself in. He attend Medication Therapy Management through his treatment program. (Def. Ex. 1).

He began consulting with a physician, who recommended that he begin dosages of what is commonly known as "medical cannabis" or "medical marijuana" under Minnesota's statutory regime. Medical records verified that the pain-specialist physician observed: (i) Mr. Schostag had made attempts to treat his symptoms via non-drug therapies; (ii) medical cannabis would be far superior to highly-addictive alternatives like opioids; (iii) medical cannabis had the potential to improve his symptoms of pain, anxiety, and depression, amongst others. His primary care physician was fully aware of this, and included it in his regimen of medications (along with a great many others to treat numerous health conditions).

His addiction treatment healthcare provider carefully examined the idea of medical cannabis to improve his overall health, and issued a letter to the probation office expressing "support [for] his use of medicinal cannabis as prescribed by his doctor for pain control." (Def. Ex. 2).

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So, fully within the parameters of a healthcare professional opinion and Minnesota state law, he attained a credential for the procurement of a cannabinoid product for medicinal purposes. And he began using it as directed. (Def. Ex. 1 and 2)

All was going well. But when the probation office administered a routine drug test, the results (unsurprisingly, given the above facts) came back positive for marijuana. Mr. Schostag candidly informed the probation office about the arrangement just described, and reported that he was then using "medical cannabis as prescribed in the dose of three to four puffs daily at night time." (VR 2). He was in compliance with the court's order that he "take all take any prescribed medications as directed by his medical provider." (DCD 739).

The probation office noted that: (i) he has been compliant with therapy and communicative with the probation office; (ii) he has been compliant with and made progress in addiction treatment; (iii) he has had numerous health problems, including trouble maintaining sobriety and difficulty with chronic pain. Nonetheless, the probation office viewed the medical cannabis usage as a violation of the above-quoted condition of supervised release concerning "unlawful use of a controlled substance," and moved for revocation or other appropriate action, reasoning:

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> Regardless of the defendant's reasons for using marijuana, the use of marijuana is strictly prohibited and illegal under federal law as it is considered a Schedule I controlled substance. Specifically, Schedule I substances have a high potential for abuse and do not currently have accepted medical use in treatment in the United States [21 U.S.C. § 812]. While some states have legalized the use of marijuana for medicinal purposes, where federal and state law conflict, federal law is controlling (United States Constitution, Article Six, Clause Two).

(DCD 1298; VR 4).

At the revocation hearing, the government acknowledged Mr. Schostag's good progress on supervised release, and said it would not be seeking major sanction. Rather, based upon its understanding of the law, it sought "a clear message from the Court that [Mr. Schostag] cannot use medical cannabis given his status on supervised release." (RHT 7-8).

Mr. Schostag countered that the district court should permit him to continue using medical cannabis, owing to the "unique circumstances" of his chronic pain and addiction, as just explained. (RHT 4-6). He submitted documentation from healthcare professionals—including addiction treatment professionals—supportive of the medical cannabis regimen. Although all parties had copies of the medical cannabis card and the treatment, the exhibits were not entered into evidence until the second violation hearing that occurred on December 18, 2017. (RHT2 5). For its part, the district court acknowledged that his addiction treatment provider was fully supportive of the medical cannabis usage. (RHT 11). And that there exists medical

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research and expert opinion that medical cannabis may be a superior alternative to other medications. (RHT 9-10, 12, 14). But the judge took the government's view that there was no other choice under the law but to explicitly disallow the medical cannabis therapy. (RHT 9 ("[T]he matter is not legally complicated because the law is clear."), 11-12 (ordering a stop to medical cannabis use absent some change "with respect to the law"); *accord* RHT 8-14 (extended discussion of the matter)).

The district court thus ordered that Mr. Schostag "shall not purchase, possesses, use, distribute or administer marijuana or possess a medical marijuana card or prescription." (DCD 1316).

Mr. Schostag objected, but to no avail. (RHT 14). All because the district court felt legally compelled to preclude usage of medical cannabis. As the remainder of this brief will show, the district court erred in limiting itself this way.

Shortly after the hearing, On July 29, August 5, August 13, and August 17, 2017, Mr. Schostag used methamphetamine. A second violation was filed on August 30, 2017 (DCD 1359). On December 18, 2017, Mr. Schostag admitted to the court he had used methamphetamine. He stated "I was, you know, the pain in my foot with the opiates, the opiates don't help. I get angry on them. So I went back to my old ways." (RHT2 6). The court continued Mr. Schostag on supervision. (RHT2 7-8).

SUMMARY OF THE ARGUMENT

Appellant John Schostag is serving a term of federal supervised release. He also suffers from a number of health problems, including addiction disorder as well as a vexing chronic pain condition. He made good progress with addiction treatment, but was unable to solve the chronic pain problem. After trying numerous medicinal and non-medicinal therapies, he consulted a physician who recommended a regimen of state-permitted medical cannabis. All his healthcare providers concurred.

A probation-office-administered drug test came back positive for marijuana. At a revocation hearing, he informed the district court of the above facts, but the district court determined it had no choice but to impose a blanket prohibition on usage of medical cannabis while under federal supervised release.

The district court erred as a matter of law in failing to recognize that it had the option to order out-of-court treatment instead, by which healthcare professionals could determine whether medical cannabis was an appropriate therapy, or not.

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ARGUMENT

I. The district court misconstrued the law and thus erroneously curtailed its own discretionary response to a violation of a condition of supervised release, *i.e.,* testing positive for medical cannabis.

As noted earlier, here the district court felt the law provided no other choice but to explicitly forbid Mr. Schostag (or anyone else) from making use of a state-law-approved medical cannabis therapy while under federal supervised release. As this discussion will demonstrate, the district court misconstrued the law and thus erroneously curtailed its own discretion.

A. In general this Court reviews supervised release decisions for abuse of discretion; but when the abuse of discretion at issue is a misapprehension of law, *de novo* review is appropriate.

The legal question at hand involves federal supervised release, governed by 18 U.S.C. § 3583. Under this system, a district court has much leeway to set conditions of supervised release, *id.* § 3583(d), modify those conditions, *id.* § 3583(e)(2), and otherwise take appropriate action in response to violations, *id.* § 3583(e)(1)-(4). As a general proposition, this Court reviews such decisions for abuse of discretion. *E.g., United States v. Winston*, 850 F.3d 377, 379 (8th Cir. 2017) (imposition or modification of conditions); *United States v. Young*, 640 F.3d 846, 848 (8th Cir. 2011) (response to violation).

That being said, a "district court abuses its discretion when it makes an error of law." *United States v. Fonder*, 719 F.3d 960, 961 (8th Cir. 2013) (citations

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omitted). This Court applies *de novo* review to such claims of legal error. *Id.* Legal error includes failure to recognize the full array of statutory and legal options in the event of a violation as to some condition of supervised release. *See, e.g., United States v. Pierce*, 132 F.3d 1207, 1208-09 (8th Cir. 1997).

Accordingly: (i) the question at hand broadly involves a supervised-release matter which is normally discretionary; but (ii) the precise issue here involves the district court's misapprehension of law in self-limiting the available array of legal options in exercising that discretion. *See, e.g., id.* Thus, this Court applies *de novo* review just as it does with any other question of law. *See, e.g., Fonder*, 719 F.3d at 961.

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B. The district court misapprehended the law so as to curtail its discretionary response to a violation of a condition of supervised release, *i.e.*, testing positive for medical cannabis.

In this case, the district court first determined that a positive drug test result indicating (medically- and state-approved) usage of cannabis constitutes a violation of federal supervised release conditions. (RHT 9, 11-12). On that specific point, the district court's decision finds plenty of support in the case law. *See, e.g., United States v. Johnson*, 228 F.Supp.3d 57, 62 (D.D.C. 2017) (collecting cases).

But as indicated earlier, the question of interest is ***not*** whether such a test result violates a condition of federal supervised release. Rather, the question is what legal options a district court has at its disposal when an individual under its supervision registers a positive test for medical cannabis. *See* STATEMENT OF THE ISSUE, *supra*. And, as relevant here, whether the district court considered the full array of legal options available to it when fashioning a response. *See id.*

The district court had discretion to respond differently that it did. The district court could have sent Mr. Schostag to out-of-court addiction treatment, such that an interdisciplinary team of healthcare professionals could make the decision as to whether continued usage of medical cannabis was appropriate or not. Similar as his doctors thought, medical cannabis was appropriate and as such was prescribed and taken by Mr. Schostag as required by his conditions of supervision (take prescribed medication.) Before demonstrating why the district court had legal authority to

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fashion such a solution, it is helpful to examine the legal and therapeutic status of medical cannabis, discussed next.

1. Legal status of medical cannabis

Owing to this nation's unique federalist system, medical cannabis (a/k/a medical marijuana)[3] presently exists in what can be described as legal limbo.

At the national level, there exists a statute claiming that marijuana "has no currently accepted medical use" and thus prohibiting it, even when a professional physician determines the medication will likely be beneficial to a patient's overall health. 21 U.S.C. §§ 812(b)(1), (c) & 844; *see also United States v. Oakland Cannabis Buyers' Coop.,* 532 U.S. 483, 491-92 (2001). Dating back to 1970, this legislative edict was imposed on the basis of scant medical evidence, certainly without the benefit of the many studies conducted during the intervening decades. *See, e.g., Gonzales v. Raich*, 545 U.S. 1, 10-15 & 27 n.37 (2005).

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[3] Discussions of this topic often times use the terms "medical cannabis" and "medical marijuana" interchangeably. And this brief does so too. However, the current scientific literature indicates the term "cannabis" is broader so as to embrace a great many products derived from the *cannabis sativa* plant (*e.g.,* chemical compounds known as cannabinoids, the marijuana plant itself, etc.) commonly employed for medically-approved usage. Nat'l Acad. of Sciences, Eng'g & Med., *The Health Effects of Cannabis and Cannabinoids*, at 38 (2017), *available at* /https://www.nap.edu/. Accordingly, the undersigned attempts to make use of the broader term "medical cannabis" as much as practicable.

In stark contrast, as early as 2005, nine states had enacted legislation authorizing use of cannabis for medicinal purposes. *Id.* at 5 & n.1. As of the time of this writing, the tally now stands at of *29 states*, plus the District of Columbia and some territories as well. *See, e.g.,* Nat'l Conf. of State Legis., *State Medical Marijuana Laws* (Aug. 2017).[4] As relevant here, the State of Minnesota has joined these ranks by enacting its own laws authorizing usage of medical cannabis. *See* Minn. Stat. §§ 152.21-.37 (2016).

This up-to-date and burgeoning policy choice did not emerge from thin air, but rather is the product of scientific study and professional medical judgment. This nation's most highly skilled scientists and researchers have found evidence that cannabis may be an effective treatment for patients suffering from any number of medical conditions, including but not limited to: chronic pain, anxiety, post-traumatic stress disorder, multiple sclerosis, and many others. *See, e.g.,* Nat'l Acad. of Sciences, Eng'g & Med., *The Health Effects of Cannabis and Cannabinoids*, at 128-29 (2017).[5] These same investigators call for more and more studies to

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[4] *Available at* http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx/

[5] *Available at* https://www.nap.edu/catalog/24625/the-health-effects-of-cannabis-and cannabinoids-the-current-state

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determine the risks and benefits of cannabis in treating a wide range of medical conditions. *Id.* at 85-127, 395-401.

Even national governmental entities recognize the evidentiary reality as to the many (current and future) therapeutic uses for medical cannabis. For example, the Supreme Court has long acknowledged that scientific evidence "regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on the accuracy of the findings that require marijuana to be listed in Schedule I" of the Controlled Substances Act. *Raich*, 545 U.S. at 27 n.37. And the very same national Congress that enacted the prohibition in the first place has refused to fund any federal-level criminal prosecutions for medical cannabis usage countenanced under a state laws, like those mentioned a moment ago. *See* Consolidated and Further Continuing Appropriations Act of 2015, Pub. L. 113-235, § 538 (Dec. 16, 2014) ("None of the funds made available in this Act to the Department of Justice may be used, with respect to [states having enacted medical cannabis laws], to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana").

All this brings us right back to the term used to begin this discussion—legal limbo. The current national government says there exists no valid medical purpose for cannabis, which forms the sole justification for its blanket prohibition. Separately, numerous state governments (including the State of Minnesota) have

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consulted the up-to-date research and have come to the opposite conclusion, thus passing legislation to explicitly permit therapeutic usage of cannabis for treatment of a number of medical conditions.

Unfortunately, this legal limbo creates ambiguity for those charged with adhering to the law, to say nothing of those tasked with enforcing or implementing it. Included in this group are individuals like Mr. Schostag, who seek evidence-based medical treatment in conformity with state law and physician recommendations. Federal district courts, who oversee individuals like Mr. Schostag during the course of supervised release. And healthcare providers, dedicated to making decisions in the best interests of a patient's overall health and welfare. It is these healthcare professionals who are on the front lines of the competing legal mandates concerning medical cannabis. So, before, getting to the district court's legal options when faced with a supervisee who tests positive for medical cannabis, it is helpful to examine how healthcare providers resolve the ambiguity.

2. Healthcare providers' approach to medical cannabis

As just observed, the current legal limbo encompassing medical cannabis puts many stakeholders—including healthcare providers—into a challenging position. Upon reading the United States Code, they find a claim of no medical benefit, as well as a blanket prohibition. But every other available piece of information—including medical research studies, state laws, and even congressional actions—tells

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them that medical cannabis *does* have effective therapeutic functions. And that patients ought to have access to such products when professional medical judgment counsels in its favor. So what is a medical professional to do?

The literature suggests that healthcare providers give primacy to the best interests of the patient. State laws that permit medical cannabis often give healthcare providers the reciprocal right to allow and facilitate its usage. *E.g.,* Minn. Stat. § 152.34. Healthcare facilities often do permit such usage, on the ground that medical cannabis is "shown to help some [] patients" and so such care is part of the medical "mission to serve [] patients and their families." *See* M. Durkin, "Medical Marijuana in the Hospital?", *Am. Coll. Phys. Hospitalist* (Jan. 2017).[6] Even the federal agency charged with improving the quality of addiction treatment—while not endorsing medical cannabis and noting risks associated with it—stops short of forbidding its usage. *See* H.W. Clark, SAMHSA, "Dear Colleague" Letter Re: Medical Marijuana (July 28, 2014).[7] Instead, the agency emphasizes "efforts in delivering safe and high quality care that produces the best possible outcomes" for patients. *Id.*

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[6] *Available at* https://acphospitalist.org/archives/2017/01/marijuana-policies-hospital.htm

[7] *Available at* https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dear_colleague_letters/2014-colleague-letter-marijuana-use.pdf

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The upshot is, healthcare providers resolve the current legal ambiguity in their patients' best interests, and in accordance with their best professional judgment. The Court may say that's all fine with respect to healthcare providers, and yet wonder whether a federal district court has the same leeway. As will be shown next, it does. Specifically, it has the power to delegate the decision to these very same healthcare providers.

3. Legal options after positive test for medical cannabis

To state the obvious, a great many individuals subject to federal supervised release struggle with addiction. And, consequently, a great many of these same individuals return samples yielding failed drug tests. This describes Mr. Schostag's situation in the present case.

Anticipating such common scenarios, Congress has wisely provided sentencing courts with an array of choices for an appropriate response. The law permits a heavy-handed approach, allowing a district court to revoke supervised release and impose an additional prison term, for example. 18 U.S.C. § 3583(g). But recognizing such a severe result will be both unwarranted and unconstructive in many cases, the law also provides that a the sentencing court "*shall consider* whether the availability of appropriate substance abuse treatment programs, or an individual's current or past participation in such programs, warrants an exception in accordance with United States Sentencing Commission guidelines." *Id.* § 3583(d)

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(emphasis added). This Court has succinctly summarized the rule this way: "When a defendant violates a condition of his supervised release by failing a drug test . . . a district court may either sentence him to prison ***or require out-of-prison treatment***." *United States v. Kaniss*, 150 F.3d 967, 968 (8th Cir. 1998) (emphasis added); *accord, e.g., United States v. Pierce*, 132 F.3d 1207, 1208-09 (8th Cir. 1997); USSG § 7B1.4, App. N. 6.

When a district court orders someone under its supervision to substance abuse treatment just mentioned, it properly leaves the selection of program to the probation office, and the treatment regimen to the healthcare professionals. *See* USSG § 5D1.3(d)(4). Courts are loathe to "micro-manage drug treatment programs" by, for example, mandating the appropriate number and/or type of drug testing. *United States v. Stephens*, 424 F.3d 876, 883-84 (9th Cir. 2005). Instead, courts imposing treatment "allow the drug treatment professionals to determine the particularities of the treatment." *Id.* at 884 (internal punctuation omitted); *accord, e.g., United States v. Carpenter*, 702 F.3d 882, 885 (6th Cir. 2012) ("[T]he details of the treatment, including how often and how many drug tests will be performed, can be left to the expertise of the professionals running the program." (citation omitted)).

This is a solution the district court should have considered here. Mr. Schostag could have worked with the probation office to select a treatment program that would assist him in solving the vexing problem of simultaneous addiction and chronic pain.

Once the treatment professionals became involved, perhaps they would have said Mr. Schostag's proffered solution of state-law-permitted medical cannabis was in the best interests of the patient. Or, they may have concluded that usage was too risky, vis-à-vis the expected benefits. Either way, the district court should have left the matter to the healthcare professionals who staff the chosen treatment program.

The district court could have and should have at least considered this sort of treatment option. Particularly in this case, where Mr. Schostag has been compliant with this probation officer, and was merely seeking a solution for his vexing addiction/chronic-pain dilemma. In this way, the healthcare decisions are placed in the capable hands of professionals with the necessary specialized expertise. Courts have long deferred to such healthcare professionals, and should do so here as well.

This subject matter is difficult because of the competing federal and state laws. Respectfully, Mr. Schostag is just asking he be allowed to take his prescribed medical marijuana that is allowed by his doctor and most likely will agreed upon with this treatment facility given Defense Exhibit 2.

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CONCLUSION

Mr. Schostag requests that this case be reversed and remanded to the district court, with instructions to consider the full array of legal options available.

Dated: January 5, 2018

s/Manny K. Atwal

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MANNY K. ATWAL
Assistant Federal Public Defender
U.S. Courthouse, Suite 107
300 South Fourth Street
Minneapolis, MN 55415
(612) 664-5858
Counsel for Appellant

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In the
UNITED STATES COURT OF APPEALS
For the Eighth Circuit

UNITED STATES OF AMERICA,	)	Appeal No. 17-2530
	)	
v. Appellee,	)	
	)	**CERTIFICATE OF COMPLIANCE AND OF VIRUS FREE ELECTRONIC BRIEF**
JOHN EDWARD SCHOSTAG,	)	
	)	
Appellant.	)	

I hereby certify that the Brief of Appellant filed in contains 4,312 words, excluding the table of contents, table of citations, statements with respect to oral argument, addendum and certificates of counsel and service, as counted by the word-processing system (Microsoft Word) used to generate the brief. The brief otherwise complies with the type-volume limitations and typeface requirements set forth in F.R.A.P. 32(a)(7)(B) and (C) and Eighth Circuit Rule 28A(c).

I also certify that the electronic brief has been scanned for viruses and is virus free.

Dated: January 5, 2018

Respectfully submitted,

s/Manny K. Atwal

MANNY K. ATWAL
Assistant Federal Defender
District of Minnesota

U.S. Courthouse, Suite 107
300 South Fourth Street
Minneapolis, MN 55415
612-664-5858

Attorney for the Appellant

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In the
UNITED STATES COURT OF APPEALS
For the Eighth Circuit

United States of America, v. Appellee, John Edward Schostag, Appellant.	Appeal No. 17-2530 **CERTIFICATE OF SERVICE**

The undersigned hereby certifies that she is an employee of the Office of the Federal Defender for the District of Minnesota and that on January 5, 2018 she served the following documents electronically through CM/ECF to the below-listed party:

A. Brief of Appellant;
B. Certificate of Compliance (bound in brief).

Nathan P. Petterson, AUSA

s/ Tracey Bodway

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